

Autism/Autism Spectrum Disorder, Diagnosis, & Treatment

Origination: 03/17/09	Revised:	Annual Review: 12/15/11
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Purpose:

The Medical Technology Assessment Committee will review published scientific literature and information from appropriate government regulatory bodies (when available) related to Autism/Autism Spectrum Disorder, Diagnosis, & Treatment in order to determine inclusion in the benefit plan.

Compliance Status:

- Florida Statutes – 641.31098 *Coverage for individuals with developmental disabilities*

Definitions:

- Autism is contained within a category of conditions called Pervasive Developmental Disorders (PDD). There are five (5) conditions that fall under PDD, and Autism is one (1) of them.
- For coverage purposes, Autism is defined by The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders DSM-IV*. The diagnosis of Autism requires that at least six (6) developmental and behavioral characteristics are apparent, that the problems are evident before age three (3), and that there is no evidence for certain other conditions that are similar. Besides Autism, the other conditions included in the Autism Spectrum Disorder (ASD) are Autistic Disorder, Asperger's Disorder, and Pervasive Developmental Disorder not otherwise specified. Each has specific characteristics listed in the DSM-IV.

Recommendation:

A recommendation was made by the MTAC following discussion by committee members based on current literature:

Eligibility Criteria

- Genetic testing for Autism/ASD is only covered for the following situations:
 - FMR1 gene mutation when fragile X syndrome is suspected
 - MECP2 gene mutations when Rett's Disorder is suspected
 - Carrier testing when there is a positive family history of Fragile X syndrome or Rett's disorder in a first- or second-degree relative
 - Screening for ASD in the general population is not a covered benefit

Recommendation, continued:

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Exclusions

- The following procedures/services for the assessment of Autism/ASD are NOT covered as are considered experimental and/or investigational. This includes, but is not limited to:

Assessment:

- Allergy testing (e.g., food allergies for Gluten, Casein, Candida, molds)
 - Celiac antibodies testing
 - Erythrocyte Glutathione Peroxidase studies
 - Event-related potentials (i.e., Evoked Potential Studies)
 - Hair analysis
 - Immunologic or neurochemical abnormalities testing
 - Intestinal permeability studies
 - Magnetoencephalography (MEG)
 - Micronutrient testing (e.g., vitamin level)
 - Mitochondrial disorders testing (e.g., Lactate and Pyruvate)
 - Neuropsychological testing (see separate policy)
 - Stool analysis
 - Urinary peptides testing
- The following services are NOT covered for the assessment and/or treatment of Autism/ASD because they are primarily educational and training in nature, and are not covered under most benefit plans. This includes, but is not limited to:
 - Education and achievement testing
 - Educational intervention (e.g., classroom environmental manipulation, academic skills training and parental training)

- The following procedures/services for the treatment of Autism/ASD are NOT covered as are considered experimental and/or investigational. This includes, but is not limited to:

Treatment:

- Auditory Integration Therapy (AIT)
- Augmentative and Alternative Communication (AAC) therapy and devices
- Chelation therapy
- Cognitive behavioral therapy
- Cognitive rehabilitation
- Cranio-sacral therapy (CST)
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Recommendation, continued:

Exclusions, continued

- The following procedures/services for the treatment of Autism/ASD are NOT covered as are considered experimental and/or investigational. This includes, but is not limited to, continued:

Treatment, continued:

- Dietary and nutritional interventions including, but not limited to Gluten-free Casein-free (GFCF) diets, Elimination diets, Vitamins, Digestive enzymes, Probiotics, Yeast-free diets, The Specific Carbohydrate Diet (SCD), Periactin, Carnosine, Omega-3 Fatty Acids
- Facilitated Communication (FC)
- Gentle Teaching Program
- Hemi-Sync audio technology
- Holding Therapy
- Hyperbaric oxygen therapy
- Immune globulin therapy (IVIG)
- Music, Vision, Art, Hippotherapy, or Animal therapy
- Option Program, or Son Rise Program
- Secretin, Growth Hormone, or Dimethylglycine (DMG) infusion
- Sensory Integration Therapy (SI)
- Social-Communication, Emotional Regulation and Transactional Support Program (SCERTS)
- Treatment and Education of Autistic and related Communication handicapped Children Program (TEACCH)
- Treatment tools including, but not limited to Earobics, Fast for Word, Floor Time, Joint Action Routines, Social Stories/Comic Strip Conversations, Visually Cued Instruction Technique

References:

1. American Academy of Child & Adolescent Psychiatry (AACAP). Policy statement facilitated communication. Approved by Council, October 20, 1993.
2. American Academy of Child & Adolescent Psychiatry (AACAP). Policy statement. Secretin in the Treatment of Autism. Revised and approved by Council June 15, 2002. Accessed February 28, 2007.
3. American Academy of Pediatrics. Committee on Children with Disabilities. Technical report: the pediatrician's role in the diagnosis and management of autistic spectrum disorder in children. Pediatrics. 2001 May;107(5):E85.

References, continued:

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4. American Academy of Pediatrics. Committee on Children with Disabilities. Developmental surveillance and screening of infants and young children. *Pediatrics*. 2001 Jul;108(1):192-6.
5. American Cancer Society (ACS). Hyperbaric oxygen therapy. Updated 2000. Accessed February 28, 2007.
6. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR). Washington, D.C. American Psychiatric Association APA, 2000.

Disclaimer Information:

Coverage Issues Guidelines and Medical Technology Assessment Recommendations are developed to determine coverage for AvMed Health Plans' benefits, and are published to provide a better understanding of the basis upon which coverage decisions are made. AvMed Health Plans makes coverage decisions using these guidelines, along with the Member's benefit document. The use of this guideline is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated.

Coverage Issues Guidelines and Medical Technology Assessment Recommendations are developed for selected therapeutic or diagnostic services found to be safe, but proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the AvMed Health Plans service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations.

Treating providers are solely responsible for the medical advice and treatment of Members. This guideline may be updated and therefore is subject to change.